MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4985

CERTIFICATE OF DEATH

04973

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
d. STREET ADDRESS: Rt. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Levin — Middle — Last Bayne

4. DATE OF DEATH: Month April — Day 29 — Year 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 8, 1880

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Noah Bayne

14. MOTHER'S MAIDEN NAME: Maria ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 220-10-8401

17. INFORMANT — Address: Emma Bayne - Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis with Rt Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): Hypertensive Cardiovascular Disease — Several years
DUE TO (c): Arteriosclerosis, generalized severe — Many years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 24 Oct. 1957 to 28 April 1961, that (I) (we) last saw the deceased alive on 28 April 1961, and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE: N. E. Sartorius, Jr M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): N.E.Sartorius, Jr., M.D.

22d. ADDRESS: 114 Market St., Pocomoke City, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-3-61
23c. NAME OF CEMETERY OR CREMATORY: St. Luke Holiness
23d. LOCATION (City, town, or county) (State): Pocomoke, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Edgar Wharton - New Church, Va.

25a. REC'D BY REGISTRAR DATE MAY 4 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4986

CERTIFICATE OF DEATH

04974 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D. 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City
d. STREET ADDRESS: R.F.D. 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First BESSIE — Middle MAE — Last BLADES

4. DATE OF DEATH: Month April — Day 21 — Year 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: April 5, 1910

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John William Taylor

14. MOTHER'S MAIDEN NAME: Lula Dunston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: --0

17. INFORMANT: Howard F. Blades, Pocomoke City, Md. — Address R.F.D. 3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
422.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to 4-21, 19 61, that I last saw the deceased alive on 4-19, 19 61, and that death occurred at 1 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C E Critcher M.D. — ADDRESS (Street, city or town, state): New Church, Virginia — DATE SIGNED: 4-21-61

PHYSICIAN'S NAME (Type): C. E. CRITCHER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-23-61

22c. NAME OF CEMETERY OR CREMATORY: Goodwill Methodist

22d. LOCATION (City, town, or county) (State): Rural-Pocomoke City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson — ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR — DATE: APR 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4987

CERTIFICATE OF DEATH

04975

M

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: 1 BROAD ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle PURNELL Last BOSTON

4. DATE OF DEATH: Month APRIL Day 7 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 13, 1893

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BERLIN MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: WILLIAM R. PURNELL

14. MOTHER'S MAIDEN NAME: ANNIE MAC GREGOR.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. J. SELBY PURNELL Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Non-pigmented malignant sarcoma — INTERVAL BETWEEN ONSET AND DEATH: 6 years
DUE TO
190.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/25 1960 to April 7 1961, that (I) (we) last saw the deceased alive on April 7 1961, and that death occurred at 7:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE: J. H. Thomas M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. H. THOMAS

22d. ADDRESS: Ocean City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/9/61

23c. NAME OF CEMETERY OR CREMATORY: BUCKINGHAM

23d. LOCATION (City, town, or county) (State): BERLIN MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Anne A. Burbage ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: APR 11 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1

Item 9 Film G286 5/1/61 iwk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4983

Reg. Dist. No. 04976

1. PLACE OF DEATH
a. COUNTY: Worcester Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin Md.
c. LENGTH OF STAY IN 1b: 7yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Berlin

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin RFD #1
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nellie Middle Coard Last
4. DATE OF DEATH: Month 4 Day 11 Year 1961

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 2, 1871
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Berlin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? unknown
14. MOTHER'S MAIDEN NAME: Ella Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
INFORMANT: Selena Hudson Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction	2 months
DUE TO	Essential Hypertension	Several Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Degenerative Heart Disease	"

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatoid Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 11/20, 1956, to p 4/10/1961, that I last saw the deceased alive on 4/10/, 1961, and that death occurred at 10:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory U. Sully, Jr. MD — ADDRESS (Street, city or town, state): Berlin, Md — DATE SIGNED: 4/13/61

PHYSICIAN'S NAME (Type): Ivory U. Sully, Jr., MD — Berlin, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-17-1961
22c. NAME OF CEMETERY OR CREMATORY: Berlin Town Cem
22d. LOCATION (City, town, or county) (State): Berlin Md

23. FUNERAL DIRECTOR'S SIGNATURE: Harper McWest — ADDRESS:
24a. REC'D BY REGISTRAR DATE: APR 25 '61
24b. REGISTRAR'S SIGNATURE: Darling L. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4989 Reg. Dist. No. 04977

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke (Rural)
c. LENGTH OF STAY IN 1b all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Worc
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City (Rural)
d. STREET ADDRESS Route 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Edward Middle Last Corbin
4. DATE OF DEATH Month Apr. Day 18 Year 1961
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar. 19, 1902
9. AGE (In years last birthday) 59 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Mill Work
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Corbin
14. MOTHER'S MAIDEN NAME Addie ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Bernie Schofield Address 631 N. Main St. Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conflagration
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) (County) Worc (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE N. E. Sartorius Sr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) N. E. Sartorius Sr
DATE SIGNED 4/19/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4-23-61
22c. NAME OF CEMETERY OR CREMATORY Findley Chapel
22d. LOCATION (City, town, or county) (State) Pocomoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton ADDRESS Accomac, Va.
24a. REC'D BY REGISTRAR DATE APR 24 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Item 4 should be forwarded to the Office of Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4990

CERTIFICATE OF DEATH

Reg. Dist. No. 04978

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: 20yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Rt # 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: Rt # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HORACE Middle — Last Ellis

4. DATE OF DEATH: Month 4 — Day 19 — Year 1961

5. SEX: M

6. COLOR OR RACE: AA.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 10 1899

9. AGE (In years last birthday): ~~62 years~~ 61 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Ellis

14. MOTHER'S MAIDEN NAME: Annie Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NO

INFORMANT: Mrs. Elizabeth Baker, Address: Salisbury Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 min
DUE TO (b): Hypertensive Cardiovascular Disease — 6 years
DUE TO (c):

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Chronic Alcoholism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/17, 1954, to 4/10, 1961 that I last saw the deceased alive on 4/10, 1961, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory U Sully Jr. M.D. ADDRESS (Street, city or town, stote): Berlin, Md DATE SIGNED: 4/21/61

PHYSICIAN'S NAME (Type): Ivory U. Sully, Jr., MD — Berlin, Md — 4/21/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-23-61

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.

22d. LOCATION (City, town, or county) (State): Fruitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thornton B. Jolley — ADDRESS: Salisbury Md.

24a. REC'D BY REGISTRAR DATE: APR 28 '61

24b. REGISTRAR'S SIGNATURE: Charles S. Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4991

CERTIFICATE OF DEATH

Reg. Dist. No. 04973

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop
c. LENGTH OF STAY IN 1b 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Thomas Middle Henry Last Lewes

4. DATE OF DEATH Month April Day 30 Year 1961

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH 8-25-1886
9. AGE (In years last Birthday) 74 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Mary Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no.
17. INFORMANT Bill Lewes Address Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis ?
DUE TO (b) Carcinoma of Tongue ?
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. DUE TO (c)
141.9
INTERVAL BETWEEN ONSET AND DEATH ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr. 1, 19 61 to Apr 30, 19 61, that I last saw the deceased alive on Apr. 29, 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE Clifford E. Schott M.D. ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED
PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT MD BERLIN MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Apr. 30, 1961
22c. NAME OF CEMETERY OR CREMATORY Hamblin
22d. LOCATION (City, town, or county) (State) Whaleyville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Henry N. Watson ADDRESS Pocomoke City, Md
24a. REC'D BY REGISTRAR DATE MAY 4 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM. 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4992

CERTIFICATE OF DEATH

04980

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WEST OCEAN City
c. LENGTH OF STAY IN 1b: 1 mos.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: RURAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WEST OCEAN City
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara — Middle: A. — Last: Massey

4. DATE OF DEATH: Month: 4 — Day: 18 — Year: 1961

5. SEX: FM

6. COLOR OR RACE: AA

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-13-1875

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR Months — Days —
IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Midwife

10b. KIND OF BUSINESS OR INDUSTRY: Maternity

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Davis

14. MOTHER'S MAIDEN NAME: Carolyn Smack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address: Mrs. Ida Purnell, Berlin, Md, Rt #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Degenerative Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Several Yrs
443X
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause lost.
(b) Hypertensive Cardiovascular Disease — "
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/2, 1954, to 4/18, 1961, that I last saw the deceased alive on 4/18, 1961, and that death occurred at 11 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory U. Sully Jr. M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 4/20/61

PHYSICIAN'S NAME (Type): Ivory U. Sully, Jr., MD — Berlin, Md. — 4/20/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-22-61

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cem-

22d. LOCATION (City, town, or county) (State): Berlin, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Thornton B. Jolley, Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: APR 28 '61

24b. REGISTRAR'S SIGNATURE: Clifton S. Travers

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4993

CERTIFICATE OF DEATH

04981

M

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Berlin Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
d. STREET ADDRESS: Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

12 X-2

090

3. NAME OF DECEASED (Type or print): First CLEORA — Middle LEE — Last PHILLIPS

4. DATE OF DEATH: Month APRIL — Day 23rd — Year 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 20,1876
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Wico.County-Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

I

13. FATHER'S NAME: William Thomas Brumbley
14. MOTHER'S MAIDEN NAME: Jane Ennis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Mrs.Vivian P.Ball(Grand-Daughter) Willards, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic nephroscleritis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs-3 yrs

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension.
DUE TO (c): Arteriosclerosis,

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute upper respiratory disease (common cold)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year: N/A 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N/A
20f. (City or town) (County) (State): N/A

21. I certify that (I) (this hospital) attended the deceased from 1958 19___ to date of death 19___, that (I) (we) last saw the deceased alive on 4-23 1961, and that death occurred at 3 P. M. from the causes and on the date stated above.

22a. SIGNATURE: Frank Lewis M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Apr. 24 /1961
22c. PHYSICIAN'S NAME (Type): Dr.Frank R.Lewis
22d. ADDRESS: Willards, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr.26.1961
23c. NAME OF CEMETERY OR CREMATORY: Line Church Cem.-Near [illegible]-R.D.#Pittsville
23d. LOCATION (City, town, or county) (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY
ADDRESS: SALISBURY MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 26 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4994 (04982)

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 60 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 411 Market Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Pocomoke City
d. STREET ADDRESS: 411 Market Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SADIE — Middle O. — Last POWELL

4. DATE OF DEATH: Month April — Day 27 — Year 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1873
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Schoolteacher
10b. KIND OF BUSINESS OR INDUSTRY: Education
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sewell D. Powell
14. MOTHER'S MAIDEN NAME: Alice Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Ruth Powell, Pocomoke City, Md. — Address: 411 Market St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Ventricular Fibrillation	minutes
DUE TO (b)	Pulmonary Oedema	2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Degenerative Heart Disease	years

433.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr. 24, 1961, to Apr. 27, 1961, that (I) (we) last saw the deceased alive on Apr. 27, 1961, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Charles W. Trader M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Apr. 28, 1961
22c. PHYSICIAN'S NAME (Type): Charles W. Trader, M.D.
22d. ADDRESS: 302 Market St., Pocomoke City, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-29-61
23c. NAME OF CEMETERY: Presbyterian
23d. LOCATION (City, town, or county) (State): Pocomoke City, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson
ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR DATE: MAY 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4995 04983

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b 75 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First George Middle R. Last Purnell
4. DATE OF DEATH Month April Day 11 Year 1961
5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 25-1885
9. AGE (In years last birthday) 75/4/16
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill
11. BIRTHPLACE (State or foreign country) Snow Hill Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Wesley Purnell
14. MOTHER'S MAIDEN NAME Annie Morris
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-12-0033
17. INFORMANT Mrs Rosia L. Purnell Address 105 Pitt Street Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH 5 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-10 1961, to 4-11 1961, that (I) (we) last saw the deceased alive on 4-11 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE David Rafat M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT
22d. ADDRESS Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF April 14/61
23c. NAME OF CEMETERY OR CREMATORY Mt Wesley Cemetery
23d. LOCATION (City, town, or county) Snow Hill (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE Lelay E. Timms
ADDRESS Snow Hill, Md

25a. REC'D BY REGISTRAR DATE APR 14 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4996

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04984

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 1b: Most of his life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Berlin
d. STREET ADDRESS: 501 Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Williams — Last: Richardson
4. DATE OF DEATH: Month: April — Day: 6 — Year: 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 26 93
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tax Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Clerical
11. BIRTHPLACE (State or foreign country): Berlin Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Richardson
14. MOTHER'S MAIDEN NAME: Sadie Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 224-05-3578
17. INFORMANT — Address: MRS. E. W. RICHARDSON, BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suicide by Firearm (Coitus Pendens) — INTERVAL BETWEEN ONSET AND DEATH: Instantaneous
DUE TO (b):
DUE TO (c):
976X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bad nerves for over 3 years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted wound, Gunshot about heart-downward through heart to edge of Spine on the lower back.
20c. TIME OF INJURY: Hour 9:45 a.m. p.m. — Month, Day, Year: 4-6 1961
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Berlin (County): Worcester (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: N. E. Sartorius Sr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): N. E. Sartorius Sr M.D.
DATE SIGNED: 4/6/61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4/8/61
22c. NAME OF CEMETERY OR ~~CREMATORY~~: EVERGREEN
22d. LOCATION (City, town, or county): BERLIN (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md.
24a. REC'D BY REGISTRAR — DATE: APR 10 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4997

CERTIFICATE OF DEATH

Reg. Dist. No. 04985

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1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN (RURAL)
c. LENGTH OF STAY IN 1b: 75 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BERLIN
d. STREET ADDRESS: R.F.D #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DELLA. Middle — Last RICHARDSON

4. DATE OF DEATH: Month APRIL Day 10 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 11, 1885

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): WHALEYVILLE MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM JAMES JONES

14. MOTHER'S MAIDEN NAME: ALEXINIA SARVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

INFORMANT: MR. THOMAS QUILLEN, Address: BERLIN MD.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Essential hypertension — Some years
DUE TO (c):

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/4, 1961, to 4/10, 1961, that I last saw the deceased alive on 4/10, 1961, and that death occurred at 10:35 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory U. Sullivan Jr. M.D. — ADDRESS (Street, city or town, state): Berlin Md — DATE SIGNED: 4/11/61

PHYSICIAN'S NAME (Type): Ivory U. Sullivan, Jr., MD — Berlin, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4/13/61

22c. NAME OF CEMETERY OR CREMATORY: TAYLORVILLE CEM

22d. LOCATION (City, town, or county) (State): BERLIN (R.F.D.) MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md.

24a. REC'D BY REGISTRAR DATE: APR 13 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

4998

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04986

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke (Rural)
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worc.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City (Rural)
d. STREET ADDRESS: Route 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ester; Middle: ; Last: Schofield
4. DATE OF DEATH: Month: Apr.; Day: 18; Year: 1961
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 6, 1885
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic.
10b. KIND OF BUSINESS OR INDUSTRY: House work
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gus Bevins
14. MOTHER'S MAIDEN NAME: Ellen ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bernie Schofield Address: 631 N. Main St. Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 916.0
DUE TO (b): Conflagration — INTERVAL BETWEEN ONSET AND DEATH: Short
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town) (County): Worc. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: N. E. Sartorius Jr M.D.
EXAMINER'S NAME (Type): N. E. Sartorius
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4/19/'61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-23-61
22c. NAME OF CEMETERY OR CREMATORY: Findley Chapel
22d. LOCATION (City, town, or county) (State): Pocomoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: Accomac, Va.
24a. REC'D BY REGISTRAR DATE: APR 24 '61
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. It should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1595 — Item 14 Film C285 4/17/61 mh — 04987

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Showell
c. LENGTH OF STAY IN 1b: 5 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): XXX

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Showell
d. STREET ADDRESS: XXX
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle ELIZABETH Last STULLER
4. DATE OF DEATH: Month April Day 9 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 28, 1873
9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Nelson
14. MOTHER'S MAIDEN NAME: Susan Alice Fleagle
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Xx
(If yes give wer or dates of service): xx
16. SOCIAL SECURITY NO.: xx
17. INFORMANT: J. H. Stuller Showell, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one ceuse per line for (a), (b), end (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	
444X — DUE TO (b)	Hypertension	
Conditions, if any, which geve rise to immadieta cause (a), steting tha underlying cause last. — DUE TO (c)	Senility	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Yeer 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-15 61 to 4-7 61, that (I) (we) last saw the deceased alive on 4-5 1961, and that death occured at 7h M. from the causes and on the date stated above.

22a. SIGNATURE: Clifford E Schott — ATTENDING PHYS. X — MED. DIRECTOR ☐ — STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): CLIFFORD E. SCHOTT — 22d. ADDRESS: BERLIN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/12/61 — 23c. NAME OF CEMETERY OR CREMATORY: Church Of GOD — 23d. LOCATION (City, town or county) (State): Unionton Own, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley — ADDRESS: Selbyville, Del.
25a. REC'D BY REGISTRAR DATE APR 12 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6257 — Reg. Dist. No. 04988

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop
c. LENGTH OF STAY IN 1b: 10-yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop
d. STREET ADDRESS: Rt. #1 Box 46
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mammie — Middle N. — Last STURGIS

4. DATE OF DEATH: Month April 16th — Day — Year 19 61

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-18-95

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Turlington

14. MOTHER'S MAIDEN NAME: Agnes Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ND
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Fred Sturgis — Address: Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 7 years
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/19 19 54, to 4/9 19 61, that I last saw the deceased alive on 4/9 19 61, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ivory U. Sully Jr. M.D. — ADDRESS (Street, city or town, state): Berlin, Md — DATE SIGNED

PHYSICIAN'S NAME (Type): Ivory U. SULLY — Berlin, Md. — 4-16-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 4-16-61
22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
22d. LOCATION (City, town, or county) (State): Exmore, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: L. L. Humbles — ADDRESS: Thomas Funeral Home Accomac, Va.

24a. REC'D BY REGISTRAR DATE APR 19 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6258 04989

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Stockton
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Holland's Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Stockton
d. STREET ADDRESS: 1 --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUSAN — Middle ANNE — Last TAYLOR

4. DATE OF DEATH: Month April — Day 5 — Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 26, 1867
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Taylor
14. MOTHER'S MAIDEN NAME: Sallie Elizabeth Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Mrs J. Warren Smith, Stockton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X
(b): Arteriosclerosis Generalized — yrs
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/2 1961 to 4/5 1961, that (I) (we) last saw the deceased alive on 4/5 1961 and that death occurred at 6PM, from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D.
ATTENDING PHYS. X — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): DAVID RAFAT
22d. ADDRESS: Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-8-61
23c. NAME OF CEMETERY OR CREMATORY: Wesley Methodist
23d. LOCATION (City, town, or county) (State): Stockton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Watson — ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR — DATE: APR 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59